listed in the table. In contrast to the report of Hillman, the sexual orientation of only one patient was homosexual; seven were heterosexual and for two patients it was their first sexual experience. Only one patient knew his assailant prior to the assault and two patients experienced repeated assaults by previously unknown assailants over a period of months. Forced anoreceptive intercourse occurred in all cases, ororeceptive intercourse in two cases and active anal intercourse was demanded of one patient. Four patients had reported their assault to the police. The sexual orientation of only one assailant was known.

No patient had evidence of anal trauma or proctitis and investigations for syphilis, infection with *Neisseria gonorrhoeae, Chlamydia trachomatis* and non-gonococcal urethritis proved negative in the nine patients who were tested. Anti-HIV antibody was negative three months after the assault in all five patients who requested testing. In 1989, 36 women attended this department following rape: of these women, 11 (30%) were found to have an attributable sexually transmitted infection.

The prevalence of sexual assault of men is unknown, but the experience of "Survivors", an organisation providing care for male victims of sexual assault, confirms that this form of assault is not exceptional and usually goes unreported.[2] GUM departments can expect involvement in the management of men who have been sexually assaulted and our experience shows a spectrum of cases very different from those reported by Hillman *et al.*[1] Heterosexual "victims" comprised the major proportion of cases seen in this department but homosexual men may be more reluctant to disclose sexual assault. We found no evidence of sexually acquired infection in our patients and they were greatly relieved that their assault was not compounded by infection.

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1 Hillman RJ, Tomlinson D, McMillan A, French PD, Harris JRW. Sexual assault of men: a series. *Genitourin Med* 1990;**66**:247–50.
2 Hillman R, Taylor-Robinson D, O'Mara N. Rape and subsequent seroconversion to HIV. *Br Med J* 1989;**299**:1100.

Table Characteristics of male patients attending after sexual assault

Age (yr)	*Sexual orientation*	*Number of assailants*	*Comments on assault*
13	Heterosexual	2	Repeated attacks by previously convicted paedophiles
14	Heterosexual	2	Campsite in UK
17	Heterosexual	1	
19	Homosexual	1	Known homosexual assailant
19	No previous sexual experience	1	Repeated attacks by previously unknown assailant
21	Heterosexual	3	Prison in UK
23	No previous sexual experience	2	Mentally handicapped, strayed from hospital
25	Heterosexual	1	Abroad, when drugged
31	Heterosexual	1	Public lavatory in UK
37	Heterosexual	1	

Hillman et al reply:

We were most interested to read of the experience from Nottingham. It is very difficult to decide whether a sample of such an under-reported event as sexual assault is representative or not, and we hope that this was made clear in our article. We merely sought to provide an illustration of the different sorts of presentations which occurred to our clinic over a one year period.

The sexual orientation of male victims of sexual assault is unknown. Various reports have found that between 28%[1] and 93%[2] of victims are heterosexual, suggesting that this may be more a reflection of sample bias than the actual characteristics of the condition. In a recent community-based study of 100 male victims of sexual assault in the United Kingdom,[3] we found that 39% regarded themselves as heterosexual following in-depth supportive counselling. Reporting the assault to the police was a rare event, possibly because of fear of an unfavourable reception.[4]

The lack of evidence of anal trauma in any of the men who claimed forced receptive anal intercourse to the Nottingham clinic was surprising, as our larger survey,[3] in common with others[5] found a high incidence of genital and non-genital trauma in such victims. Likewise we found a very high incidence of sexually transmissible infections in victims, again at variance with the Nottingham experience. The exact incidence and nature of sexual assault of men is extremely difficult to ascertain, and we welcome any further information concerning this ill-understood and infrequently reported phenomenon.

1 Myers MF. Men sexually assaulted as adults and sexually abused boys. *Arch Sex Behav* 1989;**18**:203–15.
2 Doan LA, Levy RC. Male sexual assault. *J Emerg Med* 1983;**1**:45–9.
3 Hillman RJ, O'Mara N, Taylor-Robinson D, Harris JRW. Medical and social aspects of sexual assault of males: a survey of 100 victims. *Br J General Practice* (in press).
4 Law Reform Commission of Canada. *Report on Sexual Offenses*. Ottawa: Ottawa Law Reform Commission, 1978.
5 Forman BD. Reported male rape. *Victimology* 1982;**7**:235–6.

Choosing equipment for colposcopy in genitourinary medicine

I read Mr Hare's article on choosing equipment for colposcopy in *Genitourinary Medicine* with interest.[1] I wish to add two comments based on my personal experience of providing this service in a genito-urinary clinic for some years.

Video camera and television I believe have superseded the SLR/Polaroid camera attachment. Not only is it invaluable as a teaching and research tool but also in patient management. Visualisation of the abnormality or lack of it as well as subsequent diagnostic and treatment procedures where necessary, coupled with the attending doctor's or nurse's comments, enables the patient to understand the condition, thus dispelling many of the misconceptions women have of the disease and its treatment with great psychological advantage. This improves patient cooperation and compliance. While

the video cassettes can be used to record findings and procedures, introduction of a video printer will additionally produce instant polaroid photographs which are useful both in research and as a permanent record of findings for case notes. These systems are not necessarily expensive and the advantages they provide make them an important, if not essential, addition to basic colposcopy.

Referring to accessory instruments, I find that while the Kogans endocervical speculum is useful in most situations, it is of limited use if the cervical os is small as either it cannot be introduced in to the os or, having been introduced, will cause bleeding when retracted due to tearing of the cervical os and thus obscuring the view. In these situations I find the Curihara endocervical speculum invaluable as an aid to visualising the canal.

I wish to add to his list of learned societies The Northern Genitourinary Physicians Colposcopy Group (NGUPCG) which was inaugurated in 1988 of which I am secretary, and not withstanding its regional reference, now has a wide membership within the UK.

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1 Hare MJ. Choosing equipment for colposcopy in genitourinary medicine. *Genitourin Med* 1990;**66**:297–301.

Choosing equipment for colposcopy in genitourinary medicine

Mr M J Hare's article on choosing equipment for colposcopy in *Genitourinary Medicine* was an excellent contribution to what will become a valuable series. I should like to add some comments to item 2 in the article regarding "The Colposcope".

A video camera and television monitor are invaluable additions to the basic colposcope. They provide full involvement of the patient in the process of colposcopy, allowing a psychologically invaluable imaging of her disease, or lack thereof. As a teaching aid for other staff they are an excellent investment and cost need not be prohibitive. A good system needs high resolution and this is helped by not having the monitor too large a size. Clarity may be lost and exaggeration of the cervix obtained with any bleeding providing a negative image. (A high resolution 14" screen provides the best picture in my opinion.)

Visualisation allows the patient to "divorce" herself from the process of examination, biopsy and even loop or laser treatment by showing there is no pain. This aids maximal patient compliance. For those patients not wishing to observe procedures, a movable trolley is preferable to the on/off switch. This permits the assisting nurse to continue her anticipation of the operator's requirements, and teaching can still be performed.

The clear advantages accrued when performing loop diathermy or laser treatment, or just colposcopy and biopsy alone, with video facilities, lead to the conclusion that this equipment is a mandatory addition to basic colposcopy.

The article did not mention cervicography. Such cameras are available for less than £1000 and in busy departments minor degrees of cervical abnormality are often photographed using basic colposcopic techniques by nursing staff. This allows later observation of film thus obtained by an experienced colposcopist, who can decide which are worthy of more formal colposcopy, and those which can be returned to repeat cytology.[1]

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1 Singer A. New methods in diagnosis: of any value? Modern trends in Aetiology and Management of CIN. Symposium R.C.O.G. 22nd September 1988.

BOOK REVIEWS

Aids and the Lung. Edited by David Mitchel and Ashley Woodcock. London: BMJ 1990 (pp 110, £8.95). ISBN 0-7279-0289-X

This book brings together the contributions on AIDS and the lung previously published as separate papers in *Thorax* and represents a mine of useful information to all concerned with caring for HIV patients. Since respiratory infections are particularly common in this patient group, this book is of value to thoracic, genitourinary and general physicians alike.

The book is logically organised and the first chapter is concerned with infection control which is clearly of paramount importance. I am sure that the comprehensive infection control procedures that are outlined are sensible, although I have doubts that the average bronchoscopist will be easily persuaded to use a visor and face mask when bronchoscoping elderly ladies in Scunthorpe. A particularly important point that is stressed in this opening chapter is the great effectiveness of careful cleaning of bronchoscopes in reducing the HIV contamination. This is a simple and very important message, as are the data on the remarkable effectiveness of glutaraldehyde. The chapter on non-invasive investigation is particularly well written. Perhaps the most useful message of the chapter is that the chest radiograph in pneumocystis pneumonia is often typical as are the clinical findings and that when this is the case the sensitivity of these clinical data approaches 87%, with a specificity of 90%. The third chapter deals with making a definite diagnosis of pulmonary problems and centres around induced sputum and bronchoalveolar lavage. Lavage is clearly an excellent technique, whereas many centres continue to have problems with induced sputum. It is likely that except in centres with a very large work load, lavage will be preferred to induced sputum, which requires such obsessional attention to detail to yield good results.

The chapter on treatment is full of fascinating data, although occasionally there are inconsistencies. In this chapter the mortality from pneumocystis